Minimum payment to noninstitutional providers of services for individuals eligible for Medicare and Medicaid is Medicare's upper limitation. Medicaid is responsible only for the deductible and coinsurance.

Establishment of payment rates for the following types of care are provided under the program:

1. Inpatient Hospital Services-Refer to Attachment 4.19-A.

2. a. Outpatient Hospital Services. Outpatient hospital services must be provided on-site. Covered outpatient services and items by the Department will be paid in behalf of Medical Assistance clients at the lesser of customary charges or the reasonable cost of inpatient services and in accordance with the upper payment limits specified in Chapter 42 of the Code of Federal Regulations Section 447.321. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement.

i. Payment to hospitals for clinical diagnostic laboratory tests rendered to outpatients and nonpatients will be paid at a rate not to exceed Medicare's fee schedule for each of those types of services. Exceptions included in Section 2303(d) of the Deficit Reduction Act will be paid at a rate not to exceed the Department's Medical Assistance Unit, or its successor's, fee schedule.

ii. Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of:

a) The hospital's reasonable costs as reduced by federal mandates to certain operating costs, capital costs, customary charges; or

b) The blended payment amount which is based on hospital specific cost and charge data and Medicaid rates paid to freestanding Ambulatory Surgical Centers.

c) The blended rate for dates of service on or after July 1, 1995, is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount.

iii. Hospital Outpatient Radiology Services. Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services.

a) The aggregate payment for hospital outpatient radiology services furnished on or after July 1, 1995, will be equal to the lesser of:

b) the hospital's reasonable costs; or
c) the hospital's customary charges; or
d) the blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount.
e) The hospital specific amount will have operating costs and capital amounts reduced by any percentages mandated by the federal government for the Medicare program.

iv. Reduction to Outpatient Hospital Costs. With the exception of Medicare designated sole community hospitals and rural primary care hospitals, all other hospitals' outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital component.

v. Patient Education: Outpatient Hospital Diabetic Education and Training Programs - Limited diabetic education and training services rendered through programs recognized by the American Diabetes Association, or provided by Certified Diabetes Educators are reimbursed at the lower of the provider's actual customary charge, or the allowable charge as established by the Department's fee schedule.

b. Rural Health Clinics - Payment for rural health clinic services may not exceed the fee schedule established by Medicare and is limited to those services specified in the Medical Assistance Manual Section 03.9145. Specifically included are services of physicians, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, nurse midwives, or other specialized nurse practitioners, supplies that furnished incidental to professional services, part-time visiting nurses' care and related medical supplies furnished to home-bound recipients in a home health shortage area, and other ambulatory services furnished by the clinic.

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c. Federally Qualified Health Center (FQHC) - Effective retroactively to April 1, 1990, federally qualified health centers are defined as community health centers, migrant health centers, providers of care for the homeless, outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act, as well as clinics that qualify but are not actually receiving grant funds under section 329, 330, or 340 of the Public Health Service Act may provide ambulatory services to Medical Assistance recipients.

i. Care and Services Provided - FQHC services are defined as follows:

a. Physician services;

b. Services and supplies incidental to physician services including drugs and biologicals which cannot be self administered; or

c. Physician assistant services; or

d. Nurse practitioner services; or

e. Clinical psychologist services; or

f. Clinical social worker services; or

g. Services and supplies incidental to a nurse practitioner, physician's assistant, clinical psychologist or clinical social worker services as would otherwise would be covered if furnished by or incident to a physician services; or

h. In the case of an FQHC that is located in an area that has a shortage of home health agencies, part-time or intermittent nursing care and related medical services to a home bound individual; and

i. Other Title XIX payable ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide.

j. Pneumococcal or immunization vaccine and its administration.

ii. Encounter - An encounter is a face-to-face contact for the provision of medical service between a clinic patient and a physician, physician assistant, nurse practitioner, clinic social worker, clinical psychologist, or other specialized nurse practitioner.

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2. c. FQHC (continued)

a. Contacts with more than one (1) health professional or multiple contacts with the same professional in the same day and in the same location constitute a single encounter unless the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

(1) A core service ordered by a physician who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter.

(2) Multiple contacts with clinic staff of another discipline (as defined in Attachment 4.19-B c.ia-h) on the same day are considered a single encounter.

b. Other ambulatory services, not counted as an encounter or reimbursed under an encounter rate, which an FQHC may use its employees or may subcontract, includes radiology, physical therapy, occupational therapy, speech therapy, audiology services, dental services, pharmacy services, independent laboratory services, physician specialists, optometry, nutritional education or dietary counseling and monitoring by a registered dietician, ambulance and other medical services which are rendered safely, efficiently and effectively.

iii. Conditions of Participation - A qualified FQHC applicant will be recognized as a Medicaid provider with the following stipulations:

a. The provider is confirmed as eligible by the Public Health Service and HCFA on and after April 1, 1990; and

b. The FQHC applicant will simultaneously terminate its Medicaid Rural Health Clinic and other Department specified Medicaid agreements from which the FQHC may provide recipients with medical services and supplies at other than reasonable cost reimbursement.

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c. Written agreements between the provider and subcontractors will state that the subcontractors retain the related records for at least three (3) years after each provider's fiscal year end. The written agreements will assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services, or their respective designee. The agreement will specify that failure to maintain such records voids the agreement between the subcontractor and the provider.

iv. REIMBURSEMENT - GENERAL.

The aggregate reimbursement for all covered services and supplies provided by an FQHC shall be equal to no less, and shall not exceed, one hundred percent (100%) of the reasonable costs related to patient care allowed under 42 CFR 413, and as appropriately clarified by the Secretary of Health and Human Services for Medicare principles of cost reimbursement.

a. Screening Guidelines of FQHC Staff Productivity - Payments for FQHC services will be applied to test the reasonableness of the FQHC health care staff. The greater of actual total encounters or total encounters expected will be used to calculate the cost per encounter. The screening guidelines are as follows:

(1) A least four thousand two hundred (4,200) visits per year per full time equivalent physician employed by the FQHC; and

(2) At least two thousand one hundred (2,100) encounters per year per full time physician assistant or nurse practitioner employed by the FQHC; or

(3) If staffing levels consist of various combinations of physicians, nurse practitioners, physician assistants, a combined screening approach may be used. For example, if a FQHC has three physicians and one nurse practitioner, calculate the screening guidelines as follows: 3 x 4,200 = 12,600 plus 1 x 2,100 = 2,100 for a total of 14,700 visits.

(4) If the Medicare Intermediary waives or adjusts the total number of encounters determined under the productivity guidelines for a specific fiscal period, the Department may also waive or adjust the productivity guidelines.

(5) A full time equivalent for purposes of this section is two thousand eighty (2,080) hours per year, forty (40) hours per week for fifty-two (52) weeks.

b. Offset, Reclassified or Excluded Costs - The costs of the specific following items and services are to be offset, reclassified, or excluded from Medicaid reasonable costs:

(1) Excessive and unreasonable costs which violate the prudent buyer concept are excluded from total costs; and

(2) Medicaid payments for presumptive eligibility screenings shall be offset against the appropriate cost centers at cost settlement; and

(3) Special services related to pregnancy with the exception of nutritional education and dietary monitoring and counseling will be included as encounters in cost report statistics and for cost settlement;

(a) Other ambulatory services not included in the definition of an encounter shall be reimbursed at one hundred percent (100%) of reasonable costs;

(b) EPSDT screening and the incidental services are a patient encounter. Services and items specifically not included in the Idaho Title XIX state plan but authorized as EPSDT services through section 6403 of O.B.R.A. 1989 may be reimbursed on either a fee for service basis or reported as other ambulatory services for cost settlement.

(c) EPSDT services not outside the scope of Medicaid will be reimbursed at 100% of reasonable costs for MA recipients up to and including the month of their twenty first birthday. Limits upon the number or scope of services for EPSDT recipients are not waived for an FQHC provider.

v. **Reasonable Costs of FQHC Services.**

(a) Ambulatory services will not be considered an encounter. The direct cost and related customary charges of each ambulatory service provided will be accounted for in an independent cost center in the provider's financial records and the Medicaid cost report.

(b) Overhead costs will be allocated to core services, each category of other ambulatory services, and nonallowable services in proportion of the cost of each to total costs.

(c) Payments under the National Health Service Corps reimbursement program for employee salaries or wages will not be offset against allowable costs.

(d) Other ambulatory services will be reimbursed no more than the lesser of allowable costs or the reasonable costs reimbursed by Medicare for the same services.

(e) The maximum payment per encounter will not exceed the Medicare payment level. The FQHC reimbursement methodology includes one urban and one rural payment limit that is determined annually for the Medicare program by the Health Care Financing Administration.

vi. **Cost Report Filing Requirements**. Each FQHC provider will submit the completed Medicaid Cost Report form containing such information and worksheets as the Department's Medical Assistance Unit requires to determine Medicaid reasonable costs. The deadline will be the last day of the third month following the provider's fiscal period unless a delay is granted by the Department's Medical Assistance Unit.

a. A delay of thirty (30) days past the filing deadline may be granted by the Department's Medical Assistance Unit if a written request for deferral of submittal is received prior to the filing deadline. The request must state specifically the reasons and/or extraordinary circumstances which have occurred to make timely submittal of the report impossible.

b. If a provider fails to file a complete cost report by the first day of each calendar month subsequent to the deadline, the Department' Medical Assistance Unit will withhold interim payments until the provider complies. The Department's Medical Assistance Unit will send a Notice of Reduction in the encounter rate and withhold payments as follows:

(1) A ten percent (10%) reduction will be effective the second Friday of the first calendar month after the provider's deadline;

(2) Continued failure to comply will result in the complete suspension of payments on the second Friday of the second month following the deadline;

(3) Continued failure to comply by the last day of the third month following the deadline will be a breach of the Medicaid provider agreement. The provider will be ineligible for subsequent payments from this date;

(4) Upon submittal of acceptable and complete cost reporting forms, not withstanding section 3., all withheld payments will be restored to the provider without interest charges;

(5) Refusal or continued failure to comply within thirty (30) days of Medicaid suspension per subsection (3)., will be grounds for retrospective recovery of all Medicaid payments for the fiscal period to be cost settled. The provider will be terminated from the Medicaid program for at least six (6) months after payment recovery is complete.

vii. Audit or Desk Review - If certain cost items are discovered during an audit or desk review which are not related to patient care, the Department' Medical Assistance Unit staff will make the necessary adjustments to correct the report and inform the provider of the changes made.

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a. If these same non-allowable costs appear on a subsequent cost report, the provider will be notified why certain costs were disallowed and that inclusion of the same non allowable costs in the next cost report could be treated as program abuse and referred to the appropriate agencies for consideration of criminal and/or civil prosecution, or other Departmental sanctions;

b. There will be no referral where the allowability of a cost report item has been disputed and the provider has clearly indicated on the subsequent report that the particular item is still in dispute and is being included in the cost report only to establish the basis for an appeal.

viii. Consolidated Cost Reports. Costs of individual provider sites may be determined through consolidated cost reports only if prior authorization by the Department's Medical Assistance Unit is granted prior to the beginning of respective fiscal year.

a. Authorization for consolidated cost reports will be given only when there is no significant difference between the types of services, and the related customary charges or costs as provided to the general public or Medicaid population served by each site.

b. Authorization for consolidated cost reports will be given only to providers located in Idaho or which are in counties contiguous to the Idaho state border.

ix. Adequacy of Cost Information - The FQHC must maintain records which identify the costs and charges of the covered services from the site where the service was provided and which at least account for the following:

a. Identify the time in which each physician spent in direct patient care and administrative activities.

b. Reconcile the direct costs and related customary charges of each service not incorporated into the encounter rate in each fiscal period's Medicaid cost report; and

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